3 Ambulatory Surgical Center (ASC) Guidelines

3.1 Introduction

3.1.1 General Policy

This section addresses all Medicaid covered services provided in an Ambulatory Surgical Center (ASC) as deemed appropriate by the Department of Health and Welfare (DHW). This section covers the following topics as they relate to ASC services:

- Electronic and paper claims billing.
- Claims payment.
- Prior authorization (PA).
- Nursing technician and related services.
- Use of ASC facilities.

3.1.2 Covered Services

Services in an ASC facility require a Healthy Connections (HC) referral with the exception of dental procedures. See *Section 1.5 Healthy Connections (HC), General Provider & Participant Information,* for more information.

ASC facility services generally include:

- Drugs, biologicals, surgical dressings, supplies, splints, casts, implants, appliances, and equipment directly related to the provision of surgical procedures.
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.
- Administration, record keeping, and housekeeping items and services.
- Materials for anesthesia.

Implants which provide a biomedical function such as an artificial joint, pins, screws, and plates which are not routine supplies may be billed in addition to the procedure code(s) by specifying the HCPCS code which describes the implant. The claim must include documentation detailing the reason why the implants are not routine for the surgical procedure. The ASC must bill non-routine implants under a durable medical equipment (DME) provider number. See *Section 3.1.4 Payment*, for more information.

- The ASC facility must enroll as a DME provider. See *Section 3.1.4 Payment*, for more information.
- Bill the appropriate HCPCS with the ASC facility's DME provider number on a separate CMS-1500 claim form or electronically. If you have questions about whether additional codes can be billed separately, please contact the DME Unit at: **(208) 364-1830**. The following codes are separately billable.

  L0112 - L2999

  L3224 - L3225

  L3650 - L3860

  L3900 - L6693

  L6703 - L8510

  L8606

  L8619

  L9900

- Corneal tissue: Processing, preserving, and transporting (HCPCS **V2785**) is a covered benefit when the ASC facility purchases the tissue. Invoice for the purchase of the corneal tissue must be included with the CMS-1500 claim form.

Certain procedure and diagnosis codes must be prior authorized by DHW to be covered in an ASC.

The PA number must be included on the physician, hospital and, if applicable, assistant surgeon and anesthesiologist claim forms. It is not necessary to attach a copy of the PA letter to a claim form. When billing electronically, more than one PA number is allowed on the claim. PA numbers can be entered at both the header and detail level. Enter the PA number associated to the service detail in the appropriate field of the electronic claim form.

Note: Providers billing services that require PA on a paper claim form can only bill one PA number per claim, and the PA number must be included on the claim form.

3.1.3 Non-Covered Services

ASC facility services do not include the following:

- Physician services.
- Laboratory services, x-ray, or diagnostic procedures, other than those directly related to the performance of the surgical procedure.
- Prosthetic and orthotic devices.
- Ambulance service.
- DME for use in the participant's home.
- Any other service not specified in *IDAPA 16.03.09.455.01.b, Medicaid Basic Plan Benefits; Ambulatory Surgical Center Services – Provider Reimbursement.*
- Procedures appropriately performed in a physician's office or in an inpatient setting of an acute hospital.

3.1.4 Payment

Medicaid reimburses ASCs for procedures on a fee-for-service basis using a single fee for the ASC level assigned to the procedure code. Usual and customary fees are paid up to the Medicaid maximum allowance. Ambulatory surgical centers must bill using the same procedure codes used by the performing physician.

Ambulatory surgical center facility service payments represent reimbursement for the costs of goods and services recognized by the Medicaid program as described in *IDAPA 16.03.09.455 Medicaid Basic Plan Benefits; Ambulatory Surgical Center Services – Provider Reimbursement.* Medicaid pays at the rate levels established by, *IDAPA 16.03.09. 415.01.d. Medicaid Basic Plan Benefits; Outpatient Hospital Services – Provider Reimbursement; Outpatient Hospital; Hospital Outpatient Surgery.*

Ambulatory surgical centers are paid 100 percent of the established rate for the first covered procedure and 50 percent for any remaining covered procedures. If the procedure is a unilateral code, and there is no other code for the other parts, such as **28126** (Resection, single toe, each) or **28153** (Resection, head of phalanx, toe), it may be billed as many times as anatomically appropriate, for this example 10 times.

Any Medicaid payment must be accepted as payment in full for Medicaid covered services. The participant cannot be billed for the difference between the billed amount and the Medicaid reimbursed amount.

Ambulatory surgical centers may arrange for private payment with participants or the responsible party for non-covered services. In these cases, the participant or responsible party must be informed that the service will not be covered by Medicaid before services are rendered.

3.1.5 Prior Authorization (PA)

Submit PA requests with appropriate documentation to:

Division of Medicaid
Surgery Authorizations
PO Box 83720
Boise, ID 83720-0036
Fax: (208) 332-7280 or (800) 352-6044
Phone: (208) 364-1954

Note: EDS is not an authorizing agency for any Medicaid services and does not issue PA.

3.1.6 Place of Service (POS) Code

ASC services can only be billed for in the following POS:

24 Ambulatory Surgical Center

Enter this information in field **24B** on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

3.1.7 Tamper Resistant Prescription Requirements

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If Medicaid pays for the drug on a fee-for-service basis, and the prescription cannot be faxed, phoned or electronically sent to the pharmacy, then providers must ensure that the prescription meets all three requirements for tamper-resistant paper.

Any written prescription presented to a pharmacy for a Medicaid participant must be written on a tamper-resistant prescription form that contains all of the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Access to care:

The intent of this program is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

3.2 Ambulatory Surgery Policy

3.2.1 Surgical Procedures

3.2.1.1 Abortions

Medicaid will only cover a legal therapeutic abortion in order to save the life of the mother or in cases involving rape or incest. The following documentation must be provided with your claim:

- In cases where an abortion is necessary to save the life of the woman, a licensed physician must certify in writing that the woman may die if the fetus is carried to term.
- In cases of rape or incest, the claim must include:
  - o A copy of the court determination of rape or incest, or, where no court determination has been made, document that the rape or incest was reported to a law enforcement agency.
  - o If the rape or incest was not reported to law enforcement, a licensed physician must certify in writing that, in the physician's professional opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health, or
  - o A licensed physician must certify in writing that the woman was under 18 years of age at the time of the sexual intercourse.

Note: All documentation concerning abortions must include the name and address of the woman.

3.2.1.2 Hospitalization

Hospital charges for a therapeutic abortion are subject to the same restrictions as the physician's charges. The physician should send a copy of the properly completed Certification of Necessity form to the hospital with the participant. The hospital is required to include a copy of the form with their claim.

3.2.1.3 Exception for Presumptive Eligibility (PE) Participants

Medicaid does not pay for any type of abortion for participants on the Presumptive Eligibility (PE) Program. In addition, PE participants are not covered for delivery services.

3.2.1.4 Sample Certification of Necessity for Abortions

I, _____(Name of Physician),

attending physician to _____(Name of Participant)

certify that in my professional judgment, allowing this participant's present pregnancy to be carried to term will endanger her life.

Date: _____

Signature of Physician: _____

Name of Participant: _____

Address of Participant: _____

_____

_____

_____

3.2.1.5 Dilation and Curettage (D&C)

All D&C procedures require documentation in the form of an operative report, emergency department report, or office notes. Please attach required documentation to claim for submission.

3.2.1.6 Hysterectomy

Prior approval from the QIO (Quality Improvement Organization), Qualis Health, must be obtained and the PA number included on the claim form in field **23** of the CMS-1500 claim form or in the appropriate field of the electronic claim form.

Submit PA requests to:

Qualis Health
PO Box 33400
Seattle, WA 98133-0400
Fax: (800) 826-3836
Phone: (800) 783-9207

Medicaid pays for hysterectomies if the Authorization for Hysterectomy form is included with the claim. Outpatient hysterectomy claims are subject to Idaho Medicaid Medical Consultant review.

The Authorization for Hysterectomy form may be signed either before or after the surgery has been performed. If the form is signed after the surgery has been performed, the participant must sign a statement clearly stating that she was informed, both verbally and in writing, before the surgery was performed, that the hysterectomy would render her sterile.

3.2.1.7 Sample Authorization for Hysterectomy

I have been informed orally and in writing that the hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed.

Signature: _____

Date: _____

3.2.2 Dental Procedures

Dental procedures performed in an ASC do not require PA. Use procedure code **41899** for all dental procedures performed in an ASC.

3.2.3 Ambulatory Surgical CPT Codes

See the DHW Web site for a complete listing of approved ambulatory surgical CPT codes and payment levels.

Consult the *Current Procedural Terminology (CPT) Manual* for complete descriptions of the codes.

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1 Electronic Claims Submission, General Billing Information,* for more information.

3.3.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the transaction.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3 Physician Guidelines,* for more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.3.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006.

3.3.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field **24A**.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim.

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

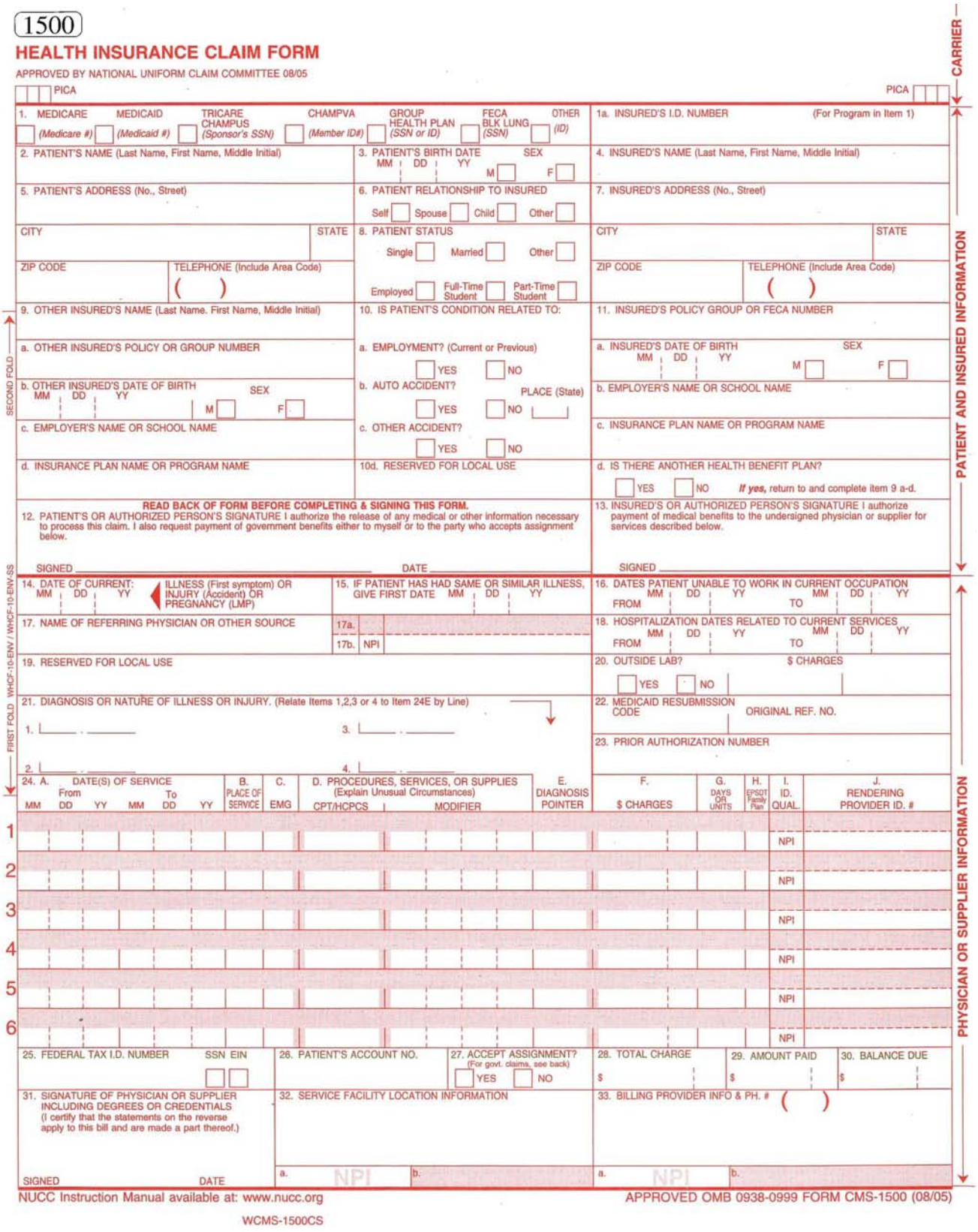
Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required, if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required, if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Patient's Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Is Patient's Condition Related to Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Is Patient's Condition Related to Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	Date of Current Illness, Injury, or Pregnancy (LMP)	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness Give First Date	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	Blank Field	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit national provider identifier (NPI) number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the internal control number (ICN) of previous claims to establish timely filing.
21 (1 - 4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate *ICD-9-CM* code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the *ICD-9-CM* primary and, if applicable, second, third, and fourth diagnosis.

Field	Field Name	Use	Directions
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	Date(s) of Service From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place-of-service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	Procedures, Services, or Supplies CPT/HCPCS	Required	Enter the appropriate 5-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Procedures, Services, or Supplies Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Pointer	Required	Use the number of the subfield (**1** - **4**) for the diagnosis code entered in field **21**.
24F	$ Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT Family Plan	Required, if applicable	Not required unless applicable. If the services performed constitute an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program screen; see *Section 1.6 EPSDT*, for more information.
24I	ID Qual	Required, if legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	The total charge entered should be equal to all of the charges for each detail line.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-On-File Form,* for more information.

Field	Field Name	Use	Directions
33	Billing Provider Info & Ph	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or remittance advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	Blank Field	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.3.3.4 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS